The long-term care facility, as exemplified by the SNF, is an anomaly presently patterned after the prototype of the acute general-care hospital. In practice, there is little resemblance between the two at the operating level.

It is suggested that the acute hospital model for SNF's be abandoned, and that nursing homes be recognized for what they are in practice. They are institutions in which nursing care is provided by nursing personnel to patients with relatively stable illnesses over long periods of time. Physicians should be relieved of *continuing* responsibility in SNF's except as professional consultants to the registered nurses as needed.

As proposed, a physician will refer his patient to the SNF, accompanied by a written history, report of physical examination, listing of diagnoses, estimation of rehabilitation potential and orders for continuing medical treatment. The physician will be required to consult with the registered nurse in person at the time of admission for appropriate interchange of information. He then will be relieved of *continuing* responsibility except as the medical consultant to the RN. The RN will be expected to formulate health care plans for the patient and to implement them professionally. When and if there is need for change in therapy, as judged by the RN, the physician will be expected to respond as consultant. He may change the orders, or he may arrange for transfer of the patient to an acute general hospital if necessary. The RN will be charged with exercising good clinical judgment in carrying out this new responsibility.

This radical departure from current practice could become operative only after exhaustive study of its legality, feasibility, practicability and morality. It would require legislative changes for its implementation as well as far-reaching realignment of physicians' attitudes. It could signal the start of a new era in the larger field of health care.

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More on Libraries

TO THE EDITOR: In the February 1978 issue, Dr. Frank and Ms. Widmeyer responded to our letter "Concerning Libraries in Small Hospitals" published in the December 1977 issue. They describe their approach as a satisfactory low cost alternative to the use of a consulting medical librarian. However, they neglect to mention their use of the reference services of the Medical Librarian of Vallejo General Hospital.

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TO THE EDITOR: To add perhaps a final note to the Vallejo library discussion[1,2] (December 1977 and February 1978), I will recount my experience. I am a pediatrician in private practice who is on the courtesy staff of the Kaiser hospital in Vallejo. This facility has a large, well-organized and beautifully maintained library which is about half a mile from the previous two Vallejo physicians' bases of operation. I have been able to use that library for the past 20 years without problem.

The letter writers have offered solutions for community hospitals without access to other facilities, not mentioning what is already available—but why simplify?

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REFERENCES

1. Seidenverg N, Quinn B: Concerning libraries in smaller hospitals (Correspondence). West J Med 127:526-527, Dec 1977
2. Frank RD, Widmeyer M: Information systems for small medical communities (Correspondence). West J Med 128:170-171, Feb 1978